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ABSTRACT

Licensing and certifying boards cannot be effective without a definition of the meaning of competence in psychology, particularly as this concept is used in psychotherapy. Research has shown that reliance on academic credentials to define competence is not the answer. Most definitions of pyschotherapy are too broad and vague, and consensus about the process involved in psychotherapy is needed. Choosing specific outcomes to define competence in psychotherapy is difficult because the determination of mental illness is highly subjective and variable. Nonetheless, without a clear picture of the process of psychotherapy, a determination of skills needed by the practitioner is impossible. All definitions of competence require specification of the percentage of clients helped or harmed, the extent of the effort, and the interpersonal areas affected by the psychotherapist's efforts. Researchers can help to define competence by focusing on the individual practitioner and his work with a variety of clients in different situations. Meta-analysis is needed to combine the results of such independent studies; however, the ability to conduct this type of analysis depends on the presence of appropriate information, reflecting the need for consistency in data collection. (NRB)

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DEFINING WHAT A COMPETENT PSYCHOTHERAPIST DOES: PROBLEMS AND PROSPECTS

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Paper presented at the 88th Annual Convention of the American Psychological Association

as part of a

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"Competence in Psychology: Hopeless Ideal or Trainable and Measurable Reality?"

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I'd like to thank Bob for inviting me to serve on this distinguished panel. The issue of competence in psychology has been a central concern of mine for many years now (Hogan, 1974, 1977, 1979), and I'm happy to have the opportunity to elaborate on some of my ideas on this matter.

I needn't spend too much time on why the issue is important. Put most bluntly, neither licensing boards nor certifying bodies such as the National Register can effectively do their jobs without an adequate definition of what constitutes competence in psychology.

In my talk today, rather than cover the whole field of psychology, I'm going to limit myself to psychotherapy. I do this for several reasons. First, it's the area with which I'm most familiar. But more important, it's the area in which definitional problems are most acute and where these definitions have the most significant political and financial repercussions.

Let me start with perhaps the most basic question that we can ask. That question is, can we define competence in psychotherapy? If you talk to most practitioners, you'll get a fairly unanimous and emphatic "no" for an answer. They'll tell you that therapeutic effectiveness is something ineffable, and that it's impossible to measure concepts like empathy, though they'll agree that empathy and other interpersonal

skills are critical to the therapeutic process. In the next breath, they'll tell you that we need strict licensing laws to protect the public from incompetent therapists. With unwavering, if unjustified, sureness, they'll argue that nobody should be allowed to practice without a Ph.D., and they'll vouchsafe that a written examination is absolutely necessary for such practice.

I'm always amazed that psychologists can feel so confident in the need for licensing laws, while asserting at the same time that competence in psychology is difficult, if not impossible, to define and measure. I'm even more amazed that so little research has been done on the relationship of academic credentials to competent practice. Psychologists are trained as researchers (at least the Boulder model would have us so believe), and yet there's been virtually no research on this matter, and one can't help but wonder why.

It seems clear to me that reliance on academic credentials is not the way to define competence in psychotherapy. Aside from evidence that I've discusssed elsewhere (Hogan, 1979), Durlak's (1979) review of the research in last year's Psychological Bulletin seems fairly dispositive of this issue. You'll recall that Durlak examined 42 studies directly comparing relatively untrained and uncredentialed practitioners with highly skilled, doctoral level professionals. In 28 cases the paraprofessionals performed as well as the pros, and in another

12 they actually outperformed their professional counterparts. In only two instances were the tables reversed. And this was the case over a wide variety of client populations, including a substantial number of psychiatric outpatients and hospitalized inpatients. It was also true over a wide variety of outcome measures that were not just limited to superficial change.

I think that psychologists are going to have a hard time countering these data, at least when it comes to defending the merits of a Ph.D. as a requirement in licensing laws. My purpose today, however, is not to argue the pros and cons of academic credentials in licensing. I've done that elsewhere, and Paul Pottinger will have quite a bit to say on that score, so I won't dwell on that here. Rather, I want to raise some fundamental issues that have been largely ignored by those measuring therapeutic competence, or any other competence, for that matter. I also want to suggest some ways that researchers can improve our chances for discovering the critical variables in the therapeutic process.

Defining precisely what constitutes psychotherapy is the initial hurdle that must be surmounted. The very first use of the term was by J. C. Reil in 1803 in an article entitled "Rhapsodies in the Application of Psychic Methods in the Treatment of Mental Disturbances" (Veith, 1958: 2). Since then the term has become a lexicographer's nightmare. Definitions abound, though many have little in common with each other, and some are antithetical.

Two major problems exist. First, there is no consensus as to what processes should properly be labelled psychotherapy. Many practitioners argue that only verbal therapies ought to be included, eliminating such methods as dance or art therapy. Others argue that therapies designed to ameliorate suffering are the only ones rightly regarded as psychotherapy, ignoring methods where the goal is self-actualization or education.

Second, most definitions themselves suffer from vagueness and overbroadness. Take, for instance, the definition recommended by the American Psychological Association (APA Committee on Legislation, 1967: 1099) for use in licensing laws (and I quote in full):

> Psychotherapy within the meaning of this act means the use of learning, conditioning methods, and emotional reactions, in a professional relationship, to assist a person or persons to modify feelings, attitudes, and behavior which are intellectually, socially, or emotionally maladjustive or ineffectual."

Let me suggest that there's not much of human behavior left out of this definition.

I personally like Victor Raimy's (1950: 93) description of the therapeutic process better. He argues that therapy is "an unidentified technique applied to unspecified problems with unpredictable outcomes. For this technique we recommend rigorous training."

What the existence of so many definitions suggests is that we need to be careful to set parameters on the therapeutic process, and we need to be more specific about what activities are and are not to be included. I suspect that for the near future we'll have many definitions vying for acceptance, and that's probably a healthy sign at this stage of our history. But it does mean that consensus is a long way off.

The second problem I want to discuss has to do with the outcomes of psychotherapy. It's fairly easy to identify what a plumber does, and although it's not as easy as it may seem, it's possible to specify desirable outcomes too. For instance, a plumber ought to be able to unblock a sink, and she or he ought to be able to install a bathtub. But what about the therapist? When we say that a practitioner is competent, what is it that he or she can do: help change behavior, self-concept, degree of insight, ability to self-actualize? In discussions of competence, rarely do I hear much mention of these specific outcomes. Certainly, I've not heard licensing boards or the National Register talk about what outcomes certified practitioners are capable of bringing about.

Significant disagreement is liable to result in choosing any set of outcomes, since the determination of mental health and illness is highly subjective and open to considerable variation. Without this delineation of potential outcomes, however, the possibility of informed choice for clients becomes meaning-

less. Without a clear picture of what psychotherapy does, a determination of what skills the practitioner needs for success is also inherently impossible. Yet licensing laws, academic training programs, and professional associations have rarely, if ever, identified the outcomes they consider desirable.

Researchers, on the other hand, have paid a great deal more attention to this issue. The work of Hans Strupp deserves special mention in this regard, especially his studies of the negative effects that result from therapy, and his efforts to identify what seems to bring these about (Strupp et al., 1977).

This brings me to the third issue of my talk. Certifying bodies have rarely specified the level of competence at which they're certifying practitioners. Even if they have done so, they frequently adopt an inappropriate and excessive level. For instance, the purpose of licensing laws is to protect the public from harm. This implies at most a minimal level of competence. Yet the American Psychological Association explicitly recommends that state licensing laws set as high a standard as possible.

But let's think for a moment about what types of standards and criteria would be appropriate to protect the public from harm. I would argue that we might license persons who only have a very narrow range of skills, if they could demonstrate that they knew when to use them, and if they knew when they were likely to lead to harm. In fact, perhaps we should license any practitioners

who could demonstrate that they wouldn't harm the public, even if they couldn't produce positive results. It's clear that the standards and criteria that would result from this analysis would be far different from those now on our statute books. In any case, where protection of the public from harm is our standard, licensing laws should not require high levels of competence.

The above discussion does not exhaust the problems involved in defining competence. One more difficulty exists that nobody, to the best of my knowledge, has yet raised. Let me describe it to you. If we say that practitioners must be minimally competent, what is it that we really mean? Are we saying that such persons must bring about modestly positive results without risking harm to anybody? Or do they perhaps harm an occasional person, but only slightly? Or do we mean that a practitioner brings about substantial benefits to most clients, but has a few who are seriously harmed, perhaps even some who commit suicide?

Each of these interpretations carries a significantly different implication for who is deemed qualified. Under the first or second standard suggested above, for instance, some brilliant therapists, who achieved cures where the average practitioner failed completely, would not be licensed if they occasionally made a few serious errors. Several internationally known psychotherapists have had precisely this reputation of being high-risk, high-gain, and they have also contributed to the field through the development of new techniques and methods. Yet, we might have to prohibit them from practicing, depending

on the definition of competence adopted in our licensing laws.

[I might add parenthetically that the research of the client-centered therapists (Rogers et al, 1967; Truax, 1963; and Truax and Mitchell, 1971) indicates that those who produce the most positive results are also those who produce the least harm. If borne out by further research, this would indeed be a happy coincidence, but Strupp has documented instances where this is not the case (see Strupp, 1980).]

What I'm saying, in sum, is that all definitions of competence require specification of what percent of clients are going to be helped or harmed, to what extent, and in what areas. How we answer these questions will determine the standards and criteria we adopt for licensing laws or in other certification processes, such as those of the National Register.

Before moving on to some suggestions for future research, I'd like to advocate a little heresy in our discussion of competence. What I mean is this. The very title of our symposium, "Competence in Psychology," suggests that the psychologist (or psychotherapist here) makes a difference. In fact, it may turn out that the therapist accounts for very little of the variance in client outcome. Perhaps the effectiveness of practitioners is simply a result of placebo effects (Shapiro, 1971). Or perhaps therapeutic effectiveness is more a matter of faith healing, than the application of technical skills. Again, maybe the client

would have improved anyway. Luborsky and his associates (1971: 149), for example, have argued that (and I quote) "possibly ... the patient's qualities are even more important for his [or her] improvement than the psychotherapy or other treatment he [or she] receives." Further, it may well be that the therapist's effectiveness results from an interaction between therapist and patient. Frank (1973: 199), for instance, suggests that therapist-patient similarity, especially with regard to values, is critical to success, and Derman (197) has argued that a major factor is therapist-client attraction.

I'd like to shift gears now and talk briefly about how ressearch might help in our efforts to define competence. Given what I've said so far, it's clear that research needs to begin focusing on the individual practitioner, providing data on how the same therapist does with a variety of clients in a variety of situations. Hans Strupp (1980) has recently done precisely this as part of his work on the Vanderbilt Psychotherapy Project, and such efforts ought to be encouraged.

But the individual study is only of limited utility in making policy decisions. No matter how thorough a single piece of research, it will always possess significant limitations, and the question will always be raised whether the results are replicable. Which brings me to the subject of meta-analysis.

One of the biggest complaints concerning the behavioral sciences has been that its research has very rarely been cumulative. While part of the difficulty has been the lack of sus-

tained focus on individual problems, much of this failure has stemmed from the lack of methods for combining the results of independent studies. Not that these methods have not existed, but social scientists have been unaware of them. Recently, with the work of Gene Glass (Smith and Glass, 1977) and the writings of Bob Rosenthal (1978; Rosenthal and Rubin, 1979; Cooper and Rosenthal, 1980), this situation has been changing. Smith and Glass's "Meta-Analysis of Psychotherapy Outcome Studies" has already become a classic, and despite some legitimate criticisms of it, the basic methodology is sound.

What I'd like to advocate most forcefully today is that much more use needs to be made of these techniques for combining independent studies. Meta-analysis. though the term sounds quite ominous, difficult, and complicated, is not that abstruse. All that's really being done is to combine a series of studies through the use of a variety of techniques from adding weighted z-scores to testing mean p-values . These methods have been simply and elegantly described by Bob Rosenthal in a series of articles in the Psychological Bulletin, which I think are must reading for those involved in literature reviews.

It's even possible to use multiple regression techniques across a set of studies, even though the individual ones within the set used nothing more than zero-order correlations. This allows the meta-analyst to control for a wide range of independent variables that the individual researcher may not have been interested in. Thus, for example, by combining a series of studies involving psychiatrists and psychologists, a meta-analyst could control for such factors as experience and client diagnosis and then determine which professional group was more effective.

But the ability to conduct this kind of analysis depends on the appropriate information being present, and this means that researchers must give us much more information than they've been in the habit of doing. Ideally, all studies would give us means and standard deviations for any moderating or mediating variables likely to have an influence on the therapeutic process. Thus, researchers should routinely provide readers with data on the sex, age, experience, education, professional affiliation, personality characteristics, and so on, for all therapist variables. Similarly, we would want information on patient characteristics, such as IQ, income level, motivation, and diagnosis. Much of this information is quite easy to compile. Even if the author does not intend to use it in his or her analysis, its provision would allow others to combine a series of such studies into an overall "meta-analysis." At the very least, all studies should report exact significance levels and effect sizes.

Unfortunately, such information is more frequently absent than present. Smith and Glass (1977), for instance, were forced to assume or guess what many of the client characteristics were in their review of therapy outcome studies. As an example, they simply assumed that all clients were neurotic unless the symptoms or labels clearly indicated otherwise. They also assumed that all clients had normal IQs unless particular diagnostic labels indicated otherwise.

I am currently conducting a meta-analysis of the empathy research to determine whether therapist empathy is related to client outcome in therapy or counseling. I am absolutely appalled at the lack of information provided in the 60 or so studies I've

located. Not only are basic demographic data on therapist and client frequently lacking, but all too often authors fail to report any standard deviations, effect sizes, or exact significance levels, making a comprehensive review nearly impossible. In addition, the typical study simply runs a zero-order correlation between empathy and outcome, or conducts a t-test comparing high and low empathizers, but without any control of other relevant variables and with no experimental manipulation.

If researchers, then, would begin to provide this kind of data, which by-and large does not involve a great deal of effort, and if policy-makers would pay attention to some of the issues I mentioned earlier in this paper, we'ed very quickly have a much better idea of what makes a therapist competent. So I'm somewhat optimistic about our chance for progress on this score, since the research methodology is theoretically adequate to the task. Perhaps, then, psychology's search for the Holy Grail of competence can indeed become a "trainable and measurable reality," not simply the search for a "hopeless ideal."

Thank you very much.

References

APA Committee on State Legislation. "A Model for State Legislation Affecting the Practice of Psychology, 1967: Report of APA Committee on Legislation." American Psychologist, 1967, 22, 1095-1103.

Berman, J. "Social Bases of Psychotherapy: Expectation, Attraction, and Outcome of Treatment." Unpublished Ph.D. Dissertation, Harvard University, Cambridge, Mass., 1978.

Cooper, H. M., & Rosenthal, R. "Statistical Versus Traditional Procedures for Summarizing Research Findings." Psychological Bulletin, 1980, 87, 442-9.

Durlak, J. A. "Comparative Effectiveness of Paraprofessional and Professional Helpers." Psychological Bulletin, 1979, 86, 80-92.

Frank, J. D. Persuasion and Healing: A Comparative Study of Psychotherapy. (Rev. ed.) Baltimore, Md.: Johns Hopkins Press, 1973.

Hogan, D. B. "Competence as a Facilitator of Personal Growth Groups." Journal of Humanistic Psychology, 1977, 17(2), 33-54.

Hogan, D. B. "Encounter Groups and Human Relations Training: The Case Against Applying Traditional Forms of Statutory Regulation." Harvard Journal on Legislation, 1974, 11, 659-701.

Hogan, D. B. The Regulation of Psychotherapists, Vol. I: A Study in the Philosophy and Practice of Professional Regulation. Cambridge, Mass.: Ballinger Publishing Co., 1979.

Luborsky, L.; Chandler, M.; Auerbach, A. H.; Cohen, J.; & Bachrach, H. M. "Factors Influencing the Outcome of Psychotherapy: A Review of the Quantitative Research." Psychological Bulletin, 1971, 75, 145-85.

Raimy, V. C. (Ed.) Training in Clinical Psychology. New York: Prentice-Hall, 1950.

Rogers, C. R.; Gendlin, E. T.; Kiesler, D. J.; & Truax, C. B. (Eds.) The Therapeutic Relationship and its Impact: A Study of Psychotherapy with Schizophrenics. Madison: Wisconsin University Press, 1967.

Rosenthal, Robert. "Combining Results of Independent Studies." Psychological Bulletin, 1978, 85, 185-93.

Rosenthal, R., & Rubin, D. B. "Comparing Significance Levels of Independent Studies." Psychological Bulletin, 1979, 86, 1165-68.

Shapiro, A. K. "Placebo Effects in Medicine, Psychotherapy, and Psychoanalysis." In A. E. Bergin and S. L. Garfield (Eds.), Handbook of Psychotherapy and Behavior Change: An Empirical Analysis. New York: John Wiley, 1971.

Smith, M. L., & Glass, G. V. "Meta-Analysis of Psychotherapy Outcome Studies." American Psychologist, 1977, 52, 752-60.

Strupp, H. H. "Success and Failure in Time-Limited Psychotherapy." Archives of General Psychiatry, 1980, 37, 595-603.

Strupp, H. H.; Hadley, S. W.; & Gomes-Schwartz, B. Psychotherapy For Better or Worse: The Problem of Negative Effects. New York: Jason Aronson, 1977.

Truax, C. B. "Effective Ingredients in Psychotherapy: An Approach to Unraveling the Patient-Therapist Interaction." Journal of Counseling Psychology, 1963, 10, 256-63.

Truax, C. B., & Mitchell, K. M. "Research on Certain Therapist Interpersonal Skills in Relation to Process and Outcome." In A. E. Bergin and S. L. Garfield (Eds.), Handbook of Psychotherapy and Behavior Change: An Empirical Analysis. New York: John Wiley, 1971.

Veith, I. "Glimpses into the History of Psychotherapy." In J. H. Masserman and J. L. Moreno (Eds.), Progress in Psychotherapy: Techniques of Psychotherapy. (Vol. 3.) New York: Grune and Stratton, 1958.